

| | | | | | | | | |
|----------------------|--------------------------------|--------------------------------|-----------|--|---------|---------|-----------|--------|
| IPDR6702 | | NORTH CAROLINA | | | | PAGE: 1 | | |
| RUN DATE: 08/07/2006 | | IPRS CHECKWRITE SUMMARY REPORT | | | | | | |
| | | CHECKWRITE DATE: 08/08/2006 | | | | | | |
| | | FINANCIAL PAYER: NCDMH | | | | | | |
| | | | | | | | TOTAL | TOTAL |
| PROVIDER | | HIGH DENIAL | NUMBER OF | | TNC | TOTAL | CLAIMS | CLAIMS |
| NUMBER | PROVIDER NAME | BOSS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404901 | SMOKY MOUNTAIN H/DD/SAS | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | | | | | | | |
| | | 0 | 0 | | 0 | 0 | | 0 |
| 3404904 | WESTERN HIGHLAN DS LME | 21 | 123 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | | | | | | | |
| | | 8534 | 105 | SERVICE FACILITY LOCATION IS N OF A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F | 0 | 510 | 6723 | 6213 |
| | | | | | | | | |
| | | 79 | 103 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN | | | | |
| 3404910 | PATHWAYS | 11 | 419 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | | | | | | | | |
| | | 8599 | 338 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 27 | 980 | 6499 | 5519 |
| | | | | | | | | |
| | | 8536 | 50 | ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR | | | | |
| 3404912 | CATAWBA COUNTVM ENTAL HEALT | 8931 | 103 | AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |
| | | | | | | | | |
| | | 8622 | 29 | 60 RESIDENTIAL LEVEL II TREATM ENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE. | 118 | 177 | 4172 | 3995 |
| | | | | | | | | |
| | | 8935 | 15 | ASTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |
| 3404913 | MECKLENBURG COM ENTAL HEALT | 11 | 1360 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | | | | | | | | |
| | | 143 | 290 | CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE | 285 | 2486 | 3640 | 1154 |
| | | | | | | | | |
| | | 8599 | 275 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| 3404916 | CROSSROADS BEHA VIOBAL HEAL | 79 | 80 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN | | | | |
| | | | | | | | | |
| | | 8599 | 50 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 0 | 247 | 12204 | 11957 |
| | | | | | | | | |
| | | 21 | 36 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| 3404917 | CENTERPOINT HUM AN SERVICES | 11 | 1150 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | | | | | | | | |
| | | 8599 | 790 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 184 | 4200 | 11840 | 7640 |
| | | | | | | | | |
| | | 8537 | 426 | PROCEDURE IS NOT PAYABLE FOR Y OUR PROVIDER TYPE AND SPECIALTY IN ACCORDANCE TO MEN | | | | |

| PROVIDER NUMBER | PROVIDER NAME | HIGH DENIAL EOBS | NUMBER OF DENIALS | DESCRIPTION | TNC DENIALS | TOTAL DENIALS | TOTAL CLAIMS FINALIZED | TOTAL CLAIMS PAID |
|--------------------|--------------------------------|---------------------|----------------------|--|----------------|------------------|------------------------------|-------------------------|
| 3404918 | ROCKINGHAM CO M ENTAL HEALT | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| 3404919 | GUILFORD CO MEN TAL HEALTHC | 8599 | 184 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 537 | 19 | PROCEDURE IS NOT COVERED FOR T HIS DATE OF SERVICE | 16 | 248 | 2037 | 1789 |
| | | 8931 | 16 | AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |
| 3404920 | ALAMANCE CASWEL L AREA MH D | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| 3404921 | ORANGE PERSON C HATHAM AREA | 5312 | 564 | PRIOR AUTHORIZED DOLLARS EXCEE DED | | | | |
| | | 27 | 474 | DIAGNOSIS CODE MISSING OR INVA LID. VERIFY AND ENTER THE CORRECT DIAGNOSIS CODE AND SUB | 0 | 1848 | 4247 | 2399 |
| | | 11 | 228 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| 3404922 | THE DURHAM CENT ER | 11 | 90 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | | 0 | 0 | | 0 | 90 | 90 | 0 |
| 3404923 | FIVE COUNTY MH | 11 | 585 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | | 8599 | 249 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 0 | 1377 | 3295 | 1918 |
| | | 21 | 179 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| 3404925 | SANDHILLS CENTE R FOR MH/DD | 21 | 603 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | 11 | 264 | CLIENT NOT ELIGIBLE ON SERVICE DATE | 44 | 1387 | 4953 | 3566 |
| | | 8599 | 144 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| 3404926 | SOUTHEASTERN RE G MENTAL HL | 8536 | 2338 | ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR | | | | |
| | | 8599 | 1394 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 83 | 5045 | 9547 | 4502 |
| | | 3411 | 822 | PROVIDER TYPE AND SPECIALTY 07 4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D | | | | |

| PROVIDER NUMBER | PROVIDER NAME | HIGH DENIAL EOBS | NUMBER OF DENIALS | DESCRIPTION | TNC DENIALS | TOTAL DENIALS | TOTAL CLAIMS FINALIZED | TOTAL CLAIMS PAID |
|--------------------|--------------------------------|---------------------|----------------------|---|----------------|------------------|------------------------------|-------------------------|
| 3404927 | CUMBERLAND CO M HC | 8599 | 120 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 21 | 90 | DUPLICATE OF CLAIM-SYSTEM | 7 | 288 | 3516 | 3228 |
| | | 8621 | 29 | 60 RESIDENTIAL LEVEL III TREAT MENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE. | | | | |
| 3404929 | LEE HARNETT MH/ DD/SAS | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| 3404930 | JOHNSTON COUNTY MNTL HLTHC | 8329 | 544 | CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS THE LMA | | | | |
| | | 8537 | 384 | PROCEDURE IS NOT PAYABLE FOR Y OUR PROVIDER TYPE AND SPECIALTY IN ACCORDANCE TO MEN | 7 | 990 | 1012 | 22 |
| | | 8599 | 50 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| 3404931 | WAKE CO HUM SVC BILLING OF | 11 | 615 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | | 8599 | 211 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | 39 | 1144 | 8449 | 7305 |
| | | 191 | 85 | CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME | | | | |
| 3404933 | SOUTHEASTERN CT R FOR MH/DD | 8599 | 43 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 21 | 38 | DUPLICATE OF CLAIM-SYSTEM | 0 | 128 | 792 | 664 |
| | | 191 | 18 | CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME | | | | |
| 3404934 | ONSLow CARTERET BEHAV HEAL | 11 | 855 | CLIENT NOT ELIGIBLE ON SERVICE DATE | | | | |
| | | 120 | 28 | CLIENT ID NUMBER MISSING OR IN VALID. ENTER CID AND SUBMIT AS A NEW CLAIM | 0 | 919 | 1033 | 114 |
| | | 8599 | 28 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| 3404935 | WAYNE CO MENTAL HEALTH CTR | 0 | 0 | *** NO DATA TO REPORT *** | | | | |
| | | 0 | 0 | | 0 | 0 | 0 | 0 |
| 3404936 | WILSON-GREENE M ENTAL HEALT | 8599 | 5 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 21 | 4 | DUPLICATE OF CLAIM-SYSTEM | 2 | 17 | 782 | 765 |
| | | 10 | 3 | DIAGNOSIS OR SERVICE INVALID F OR CLIENT AGE. VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR | | | | |

| PROVIDER NUMBER | PROVIDER NAME | HIGH DENIAL EOBS | NUMBER OF DENIALS | DESCRIPTION | TNC DENIALS | TOTAL DENIALS | TOTAL CLAIMS FINALIZED | TOTAL CLAIMS PAID |
|--------------------|--------------------------------|---------------------|----------------------|---|----------------|------------------|------------------------------|-------------------------|
| 3404937 | EDGEcombe NASH MNTL HLTH C | 8518 | 192 | CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE | | | | |
| | | 21 | 18 | DUPLICATE OF CLAIM-SYSTEM | 0 | 214 | 1772 | 1558 |
| | | 8534 | 3 | SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F | | | | |
| 3404939 | NEUSE MENTAL HE ALTH CENTER | 8599 | 13 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 21 | 12 | DUPLICATE OF CLAIM-SYSTEM | 0 | 37 | 1394 | 1357 |
| | | 79 | 5 | THIS SERVICE IS NOT PAYABLE TO YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN | | | | |
| 3404941 | PITT CO MH/DD/S AS CENTER | 21 | 5703 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | 8536 | 4909 | ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR | 68 | 14006 | 16026 | 2020 |
| | | 8537 | 1510 | PROCEDURE IS NOT PAYABLE FOR Y OUR PROVIDER TYPE AND SPECIALTY IN ACCORDANCE TO MEN | | | | |
| 3404942 | ROANoke CHOWANH UMAN SERVIC | 8931 | 6 | AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |
| | | 21 | 5 | DUPLICATE OF CLAIM-SYSTEM | 6 | 22 | 768 | 746 |
| | | 8599 | 3 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| 3404943 | ALBEMARLE MENTA L HEALTH CE | 8931 | 69 | AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS. | | | | |
| | | 21 | 44 | DUPLICATE OF CLAIM-SYSTEM | 90 | 290 | 3239 | 2949 |
| | | 8599 | 42 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| 3404944 | EASTPOINTE HUMA N SERVICES | 8536 | 564 | ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR | | | | |
| | | 8534 | 229 | SERVICE FACILITY LOCATION IS N OT A VALID IPRS ATTENDING PROVIDER. PLEASE VERIFY THE F | 1 | 1086 | 4108 | 3022 |
| | | 8532 | 129 | SUBMITTED BILLING PROVIDER IS NOT ELIGIBLE FOR DATE OF SERVICE BILLED | | | | |
| 3404946 | FOOTHILLS AREAM ENTAL HEALT | 8599 | 692 | DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE. | | | | |
| | | 537 | 488 | PROCEDURE IS NOT COVERED FOR T HIS DATE OF SERVICE | 0 | 1458 | 1965 | 507 |
| | | 24 | 161 | PROCEDURE CODE, PROCEDURE/MODI FIER COMBINATION OR PROCEDURE CODE/TYPE OF SERVICE COMBINATI | | | | |

| PROVIDER | | HIGH DENIAL | NUMBER OF | | | | TOTAL | TOTAL |
|----------|-----------------|-------------|-----------|--------------------------------|---------|---------|-----------|-------|
| NUMBER | PROVIDER NAME | EOBS | DENIALS | DESCRIPTION | DENIALS | DENIALS | FINALIZED | PAID |
| 3404957 | TIDELAND MENTAL | 8931 | 22 | AMTNC INELIGIBLE TO RECEIVE SE | | | | |
| | HEALTH CTR | | | RVICES IN IPRS. | | | | |
| | | | | | | | | |
| | | 8599 | 21 | DETAIL NOT COVERED BY COMBINAT | 33 | 83 | 365 | 282 |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |
| | | | | | | | | |
| | | 21 | 15 | DUPLICATE OF CLAIM-SYSTEM | | | | |
| | | | | | | | | |
| | | | | | | | | |
| 3404979 | NEW RIVER AREAM | 11 | 260 | CLIENT NOT ELIGIBLE ON SERVICE | | | | |
| | H/DD/SA PRO | | | DATE | | | | |
| | | | | | | | | |
| | | 21 | 130 | DUPLICATE OF CLAIM-SYSTEM | 19 | 534 | 3448 | 2914 |
| | | | | | | | | |
| | | | | | | | | |
| | | 8599 | 64 | DETAIL NOT COVERED BY COMBINAT | | | | |
| | | | | ION OF RECIPIENT, PROVIDER AND | | | | |
| | | | | BENEFIT PACKAGE. | | | | |